EMERGENCY DEPARTMENT TRANSFER COMMUNICATION (EDTC) TOOLKIT

MEDICARE BENEFICIAY QUALITY IMPROVEMENT PROJECT

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The West Virginia Hospital Association CAH Network, with support from the State FLEX program, administered by the WV State Office of Rural Health, working with Cynosure Health, is pleased to provide a best practice EDTC toolkit to support your CAH as you move forward with your quality improvement program.

I hope you find this toolkit useful, and I look forward to your feedback.

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BACKGROUND

The Emergency Department Transfer Communication (EDTC) quality measure is National Quality Forum (NQF) endorsed (NQF #291), and relevant to small rural hospitals. This measure is being implemented by critical access hospitals (CAHs) in the Medicare Beneficiary Quality Improvement Project (MBQIP) because small rural hospitals frequently transfer a higher proportion of emergency department (ED) patients than larger urban facilities. It is an important goal of MBQIP to help hospitals improve care transitions, including ED transfers, in order to reduce preventable hospital readmissions and adverse events in hospitals. As of February 2017, 86% of the 1,318 CAHs participating in MBQIP are reporting EDTC-All. (1)

The measure is composed of 7 sub-measures that are compiled into one composite measure (EDTC-All), which are calculated from 27 data elements that are abstracted from patient transfer charts. These 7 sub-measures include: administrative communication, patient information, vital signs, medication information, physician/practitioner generated information, nurse generated information, and procedures and tests. For EDTC-All, every one of the 27 data elements must be documented. (1)

DRIVER DIAGRAM

A driver diagram visually depicts the causal relationship between your overall aim and the primary drivers, secondary drivers and change ideas that "drive" the improvement. This driver diagram is provided to help you and your team identify potential change ideas to implement at your hospital as you work to improve care transition documentation.

AIM	Primary Driver	Secondary Driver	Change Idea
		Secondary Driver	Change Idea
	Primary Driver	Secondary Driver	Change Idea
		Secondary Driver	Change Idea

AIM: A clearly articulated goal describing the desired outcome. it should be specific (What), measurable (How Much), and time limited (by When).

PRIMARY DRIVER: System component for factor that directly contributes to achieving the aim.

SECONDARY DRIVER: Processes, actions that are necessary to achieve the primary driver.

CHANGE IDEAS: Specific interventions, changes that support the secondary driver.

DRIVERS IN EMERGENCY DEPARTMENT TRANSFER COMMUNICATIONS

AIM	PRIMARY DRIVER	SECONDARY DRIVER	CHANGE IDEA
	Organizational Will	Secure Leadership Commitment	CHANGE IDEAS *See below*
	Standard Work	Standardize documentation process	CHANGE IDEAS *See below*
Improve the Emergency Department Transfer Communication composite measure by 10% by September, 2018			
	Using Data for Improvement	Routine review of data related to ED transfer processes to identify areas for improvement and focus	CHANGE IDEAS *See below*
	Accountability	Develop accountability mechanisms for teams and individuals	CHANGE IDEAS *See below*

Drivers for improvement in the Emergency Department Transfer Communications include strategies that can bring positive and sustainable change to at least 7 EDTC sub-measures that are compiled into one composite measure. Many challenges currently face leaders, managers and clinicians. While ED care is important in all hospitals, it is particularly important in rural hospitals where the distance to urban tertiary facilities make effective triage stabilization and transfer of patients with the appropriate information of life or death important. ED transfer communication measures allow rural hospitals to show how well they carry out stabilization and transfer roles. Organizational Will may lead to commitment and focus, which is essential for successful ED transfer communications. As attention focuses on preventing readmissions, hospitals must improve internal processes and forge relationships with post-acute providers. Patients are most vulnerable as they move between levels of care. Often, readmissions occur when the receiving provider doesn't have adequate information to continue the plan of care. Case managers should take the time to identify patients' needs and risks for readmission and communicate clearly with the patient and caregivers about necessary steps to avoid readmission. The business definition of accountability is "the obligation of an individual or organization to account for its activities, accept responsibility for them, and disclose the results in a transparent manner." For a team to function well, an individual is not only obligated to be accountable, but they need to hold their co-workers accountable.   Team members should consistently ask for updates on clearly defined goals and openly share their own updates.

PRIMARY DRIVER:	SECONDARY DRIVER:
Create Organizational Will	Secure Leadership Commitment

	The commitment involves written leadership support, clear communication strategies, education and training opportunities, and time to perform the necessary functions to improve the transfer communications.
	
	CHANGE IDEAS:
	
	• Identify the leadership structure to support EDTC (Board, Executives, Senior Leaders, ED physician champion and ED Nursing Leader.
	   • Identify the informal staff leaders to support the process
	• Report process and outcome data to leadership on a regular basis.
	   • Identify realistic time frames for the improvement efforts.
	• Implement strategies to engage leaders and staff
	• Create will by implementing patient stories about transitions of care
	• Celebrate successes by rewarding and recognizing staff and leaders
	• Demonstrate how improvements with ED transfer communications align with other organizational priorities: How will effective transfer of patient information from ED foster continuity of patient care? decrease errors? increase handoff of information? improve outcomes? and increase patient satisfaction?
	
	https://www.ruralcenter.org/resource-library/mbqip-measures

PRIMARY DRIVER: Standard Work	**SECONDARY DRIVER:** Standardize documentation processes **CHANGE IDEAS:** • Ensure the documentation tool captures all required documentation elements • For each required element, identify who is responsible for documentation; where the documentation is found, and the time frames for completion. • Develop a grid of responsibilities and time frames with the staff. • Identify barriers to complete documentation and perform a gap analysis with specific actions. • Celebrate complete and accurate documentation by rewarding and recognizing individuals

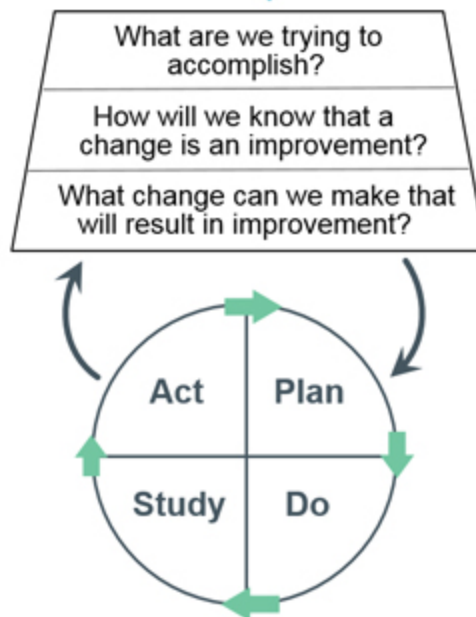|	
	• Communicate results to key stakeholders • Identify next steps. Start small.

PRIMARY DRIVER:
 	
Using Data for Improvement
	SECONDARY DRIVER:
	
	Routine review of data related to ED transfer processes to identify areas for improvement and focus
	
	CHANGE IDEAS:
	
	• Form a team that includes front line staff and leaders to review the data.
	• Analyze the data: identify strengths and opportunities at the organizational level
	   • Analyze the data by care units/settings
	   • Prioritize opportunities
	   • Identify best practices
	• Share/report results at all levels of the organization
	   • Post the results in the ED. Review the results as part of team huddles, staff meetings, etc.
	• Create positive change by celebrating organizational, team, and individual successes.
	
	https://www.ruralcenter.org/resource-library/mbqip-measures

PRIMARY DRIVER:
 	
Accountability
	SECONDARY DRIVER:
	
	Develop accountability mechanisms for teams and individuals
	
	CHANGE IDEAS:
	
	• Include front line in problem solving strategies to improve EDTC
	• Ensure staff and leaders have appropriate competencies to achieve excellent outcomes.
	• Develop a transparency board and post data
	• Identify a regular cadence of weekly huddles around the board.
	   • Focus on what is working well do more of it or make corrections.
	• Celebrate small wins and improvements
	   • Provide rewards and recognition for excellent work.
	• Identify one key area(measure) to improve; brainstorm strategies, create an action plan, and implement.
	   • Highlight benefits to the patient and transfer facility for thorough and accurate documentation.

	Watkins, L. M., & Patrician, P. A. (2014). Handoff communication from the emergency department to primary care. Advanced Emergency Nursing Journal, 36 (1), 44-51.
	http://improve.ucsf.edu/toolkit

QUALITY IMPROVEMENT PRINCIPLES

All improvement requires change. Unfortunately, not all change results in improvement. System changes intended to improve quality must be tested and assessed to determine whether they produce successful outcomes. This process of identifying needed change, planning for and making change, and then testing the outcomes of that change to evaluate effectiveness is fundamental to performance improvement in healthcare. Effective change requires an understanding not only of how one part of a system functions, but of how all the system parts are linked together and coordinated. For example, education and training for staff to enhance their knowledge and skills will only improve a system if the lack of such knowledge and skills was the major cause of deficient performance in that system. If the system has other unaddressed problems, such as lack of resources, inadequate staffing, or ineffective management or communication structures, even well-trained staff will not be able to accomplish their duties to the best of their abilities. Changes in one specific area may not lead to quality improvements if they do not significantly affect the overall quality of care the system provides.

The first step in the quality improvement process is the identification and prioritization of improvement needs, identification of an AIM statement, or improvement goal, followed by the identification of team members tasked with leading the improvement process. Key to success in team identification is the inclusion of team members involved with the system being analyzed, organizational leadership with the ability to provide resources and direction, as well as team members with expertise in quality improvement principles. Once the team is formed, the quality improvement process starts with a series of questions, followed by short, rapid cycle tests of change called the "PDSA Cycle", as demonstrated with the graphics below.

Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

Act | Plan

Study | Do

Source: The Institute for Improvement, *How to Improve*, retrieved at:
http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx

It is important that the team tasked with leading improvement be willing to test multiple ideas on a small scale, while searching for the changes that result in improved care at the local level. In quality improvement models, these multiple small tests of change are referred to as the PDSA, or Plan Do Study Act cycle. The PDSA cycle is an improvement tool which promotes improvement via the implementation of rapid-cycle tests among an increasingly larger population and a wider range of conditions. The "Plan" step in the cycle involves identifying and planning the change to be tested. The "Do" portion of the cycle is the actual act of carrying out the test on a small scale. The "Study" phase of the PDSA cycle involves rapid data collection that is done during testing through a "huddle" or "debrief" with the staff or patients involved in the newly designed process. Finally, the "Act" portion of the cycle occurs when the decision to Adapt, Abandon or Adopt is made, based on the analysis of rapidly-collected information. If revisions and changes are indicated, the process is revised or "adapted," and a new testing cycle is instituted. If the trials have been unsuccessful, the change idea may be "abandoned." The decision to "adopt" a new process occurs after it has been tested broadly under various circumstances and settings. PDSA cycles should be run among smaller groups (for example, one nurse, one physician, and during one shift to start) before gradually expanding to a larger population within the system or organization if the change is determined to be successful.
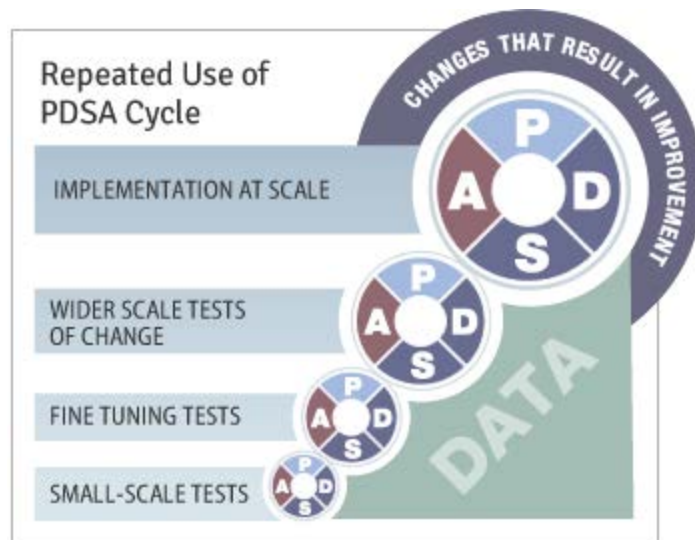
Source: Coaching and Leading https://coachingandleading.wordpress.com/presentation1/pdsa-and-types-of-change/

Quality improvement initiatives are best implemented by designated improvement teams composed of representatives from the relevant departments, units, or groups involved in the process or system to be addressed. Project management includes identification of team leadership and membership; creation of AIM statements; development of a Project Plan; selection of Tests of Change and tools for implementation, measurement, and analysis of change efforts; and communication with relevant stakeholders including senior management, medical staff, front-line staff, and patients and families about the progress and success of the improvement project. In the small hospital setting, large improvement groups may not be possible. In this setting a "hub and spoke" model for improvement work can be effective. Instead of convening large teams for every improvement initiative, one core quality and patient safety committee (the "hub"), led by a chairperson, initiates and oversees multiple improvement activities by designating a leader (or "spoke") for each initiative. Individual project leaders can be selected based on topic expertise, enthusiasm, or proximity to the process being improved. Active project implementation can be conducted in ad hoc working sessions, with the leader attending quality and patient safety meetings only upon request, if the leader is not a standing member of the quality and safety committee. This allows for improvement work to commence without interruption of duties for large groups of staff members.

BARRIERS AND CHALLENGES TO IMPROVEMENT

Partnering together to improve quality and safety is challenging work. In addition to what feels like a regular onslaught of new and competing priorities, getting on board with meaningful improvement requires a culture that supports the work, and eliminates barriers. A safety culture that supports this work requires an understanding of change management at all levels of the organization, because improvement requires change. One group that plays a significant role in the success or failure of an improvement initiative is middle managers. Without buy-in and effective leadership by middle managers to operationalize culture change, healthcare organizations will face many barriers to improvement. Few people relish the idea of changes to the comfortable status quo.

To exact positive change in the work that we do to keep patients and staff safe and improve outcomes, it takes small, incremental changes by all individuals in our organization that will build up to the large

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cultural shift that is needed for reliable improvement. Our frontline staff members are the eyes and ears of our organizations. Organizational leadership and middle managers can help to make this work safer and processes more reliable by listening to the frontline workforce when barriers and challenges are brought up and acting on the suggestions made. Organizational leadership input, encouragement and follow up can be the key to successful change.

A few keys to successful change management, and eventual cultural shifts includes the following:

- Create a sense of urgency: you are part of something big, we must make a difference now – reference not only what we know from research about the vast number of errors we are missing, but stories from actual events in your organization and your own department.
- Build a guiding coalition: organize opinion leaders and those in authority to help spread the message. Work with the willing before trying to engage those who are opposed to anything new. Let those who are enthusiastic about the new processes become the unit champions and help to spread the message.
- Form a strategic vision to help steer the change initiative: do you have a unit-specific strategic vision that is built by staff? Create that vision together at the outset.
- Enlist a volunteer army: Work with the willing. The others will come as they see enthusiasm grow.
- Enable action by removing barriers: what can you do to leverage work that is already being done? How can you help staff create time to make this a priority? Can you include a discussion about the new process in daily shift huddles and department meetings?
- Generate short term wins: Publicly celebrate the small, individual steps being made. Together they make a significant impact.
- Sustain acceleration: Keep the attention on the cultural shift by celebrating near misses that are caught and safety issues that are identified.
- Institute change: Hardwire new processes by showing how the new way of doing things has made a positive impact. Use the power of storytelling.

REFERENCES

1. Emergency Department Transfer Communication Brief, February 2017
2. MBQIP Measure Fact Sheets
3. Limpahan, L.P., Baier, R.R., Gravenstein, S., Leibmann, O., & Gardner, R. L. (2013). *Closing the loop: Best practices for cross-setting communication at the ED discharge.* The American Journal of Emergency Medicine, 31 (9), 1297-1301.
4. Samuels-Kalow, M. E., Stack, A. M., & Porter, S. C. (2012). *Effective discharge communication in the emergency department.* Annals of Emergency Medicine, 60 (2), 152-159.

REFERENCES

To assist you, we have identified a few of the key resources that you may find helpful for rural hospitals:

https://www.ruralcenter.org/resource-library/quality-improvement-implementation-guide-and-toolkit-for-cahs

https://www.ruralcenter.org/resource-library/hrsa-quality-toolkit

http://www.wsha.org/wp-content/uploads/CommEngagementToolkit_1_1.pdf

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https://greatplainsqin.org/wp-content/uploads/2014/09/Rural-Healthcare-Organization-Resources.pdf

General Improvement Tools:

https://leadingagewa.org/wp-content/uploads/WSHA-Care-Transitions-Toolkit-3rd-Edition-for-2017.pdf

https://innovations.ahrq.gov/qualitytools/care-transitions-program-toolkit

https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/connected-partnertoolkit.pdf

http://www.ihi.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx?utm_campaign=QI-Toolkit-Promotion&utm_medium=TopicLandingPage&utm_source=IHI

http://www.ihi.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx

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